

Testimony before the House Energy and Commerce Committee

Hearing on Comprehensive Health Reform

June 24, 2008

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Mr. Chairman, Mr. Ranking Member, thank you for the opportunity to testify this afternoon before the Committee. Proposals for health reform are built on a premise that only by expanding government control of healthcare can we bring down its cost. But so far, the ideas that have been offered for how to lower costs, and make medical care more efficient, seem anemic.

For example, there is no question that Medicare's payment system leads to wasteful spending. But plans to fix it – and better align pay with improved outcomes -- are, at best, incremental.

The wider adoption of electronic medical records can improve the delivery of care. But there is little independent evidence it will bend the cost curve.

Generating more comparative research on important medical questions has merit. But there is a reason the Congressional Budget Office doesn't score these proposals as saving much money.

This is why many people – including myself – worry that the end result will be greater intervention by government agencies to regulate which drugs, devices, and medical services patients can access. It seems to be the default option. The fearful case goes something like this: If we cannot adopt policies and incentives that make the individual decisions of doctors and patients more conscious of cost, then it will turn to government agencies to start making these cost considerations for all of us.

But worse still, government agencies that regulate health programs – principally the Centers for Medicare and Medicaid Services – are ill equipped to incorporate these kinds of clinical considerations into their decisions. I don't advance this in a pejorative way. The bottom line is that CMS was not conceived as an agency that would make these sorts of decisions. Their mandate was to process claims. Only incrementally, have they been tasked with making nuanced coverage decisions based on their reading of medical literature. When they have, they've often done so poorly.

I believe that there are better policy solutions than those put forward by this Committee that don't force us to have to embrace a system where the government makes these kinds of "rationing" decisions. But the bottom line is that these assessments are already being made with increasing frequency inside Medicare. If this Chamber's healthcare proposal becomes law, I believe it will become far more pervasive under a new government-run insurance plan. At the least, we owe it to ourselves to make sure decisions to regulate access to medical care are based on sound science, and a fair and transparent process. It is toward these ends that I want to briefly offer suggestions.

First, if Medicare and a new government health plan are going to take on clinical considerations in reimbursement decisions, the process for developing these clinical positions should be more highly structured and transparent. In comparison to CMS, the process used by the Food and Drug Administration is highly prescriptive, with many opportunities for submission of, and consideration of, data generated by sponsors as well as third parties. Meanwhile, the current coverage process at CMS is often opaque, with no discreet points at which the agency is required to disclose its evolving opinion and to solicit and incorporate outside data into its considerations.

Congress could direct Medicare, as well as a new government-run insurance program, to develop a much more rigorous, transparent, and structured coverage process.

Second, Medicare – and a new government insurance option – should be required to bring reimbursement policy decisions before independent, therapeutically focused advisory committees. This would again mirror the process at FDA. Right now, CMS is required to consult outside experts, but this is a largely unstructured process. Expert panels would provide discipline and expert input to the process and help to ensure that decisions reflect the practical considerations of clinical practice.

Third, if we develop a center for creating government-financed studies that evaluate competing medical treatments, under current legislative proposals, it seems inevitable that the questions that are studied will turn on economic and policy considerations, rather than purely clinical hypotheses. It seems equally likely that this information will be used to support coverage policies aimed at steering patients to lower cost alternatives. If that is the end, then we should make sure that we interpret this government-sponsored, comparative data in a consistent, transparent, and rigorous fashion. To these ends, we should develop in legislation a standard that guides when this information is actionable for decisions by government insurance programs. In many other contexts, government has clear criteria for when scientific information is sufficiently rigorous to support policy decisions.

There are other considerations that we can make in legislation to create a more rigorous and transparent process for making coverage decisions. I remain fearful that if the proposals before this Committee prevail, we will end up with a system where government health entities make an increasing number of one-sized restrictions that don't respect variation in preferences and disease.

Decisions on which medical products and services to use should be kept as close as possible to the locus where care is actually provided. The more remote these decisions become, the more we undermine the kinds of choice that allows clinicians to tailor care to patients' needs. There will also always remain an element of clumsiness when federal agencies assume these kinds of choices for us.

But if we do end up centralizing more of these clinical considerations in the context of government-directed reimbursement rules, we need to make sure that the process for making these decisions is fair and meticulous. We don't have such a system today, and it is not a consideration that, I believe, has been made in the current legislation. It is one that ought to be made before we go forward.